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Convention on the Elimination of All Forms of Discrimination against Women

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Committee on the Elimination of Discrimination against Women
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Agenda item 5
Implementation of article 21 of the Convention on the Elimination of All Forms of Discrimination against Women

Reports provided by specialized agencies of the United Nations on the implementation of the Convention in areas falling within the scope of their activities

Note by the Secretary-General

Addendum

World Health Organization

1. On behalf of the Committee, the Secretariat invited the World Health Organization (WHO), on 18 November 1999, to submit to the Committee by 20 December 1999 a report on information provided by States to WHO on the implementation of article 12 and related articles of the Convention on the Elimination of All Forms of Discrimination against Women, which would supplement the information contained in the reports of the States parties to the Convention that will be considered at the twenty-second session.

2. Other information sought by the Committee refers to activities, programmes and policy decisions undertaken by WHO to promote the implementation of article12 and related articles of the Convention.

3. The report annexed hereto has been submitted in compliance with the Committee's request.

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Annex

Report of the World Health Organization on information provided by States on the implementation of article 12 of the Convention

INTRODUCTION

Article 12 of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) requires States Parties to "take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning". The article further draws particular attention to "appropriate services in connection with pregnancy, confinement and the postnatal period". The Beijing Platform for Action (1995) builds on this article and strengthens it by specifying five strategic objectives (C.1 - C.5) as follows:

- increase women's access throughout the life-cycle to appropriate, affordable and quality health care, information and related services;
- strengthen preventive programmes that promote women's health;
- undertake gender-sensitive initiatives that address sexually transmitted diseases, HIV/AIDS, and sexual and reproductive health issues;
- promote research and disseminate information on women's health; and
- increase resources and monitor follow-up for women's health.

This report presents currently available data on selected health indicators for countries submitting first or second reports to the Committee on the Elimination or Discrimination against Women (India, Jordan, Myanmar and the Democratic Republic of Congo) under four main headings: sexual and reproductive health; HIV/AIDS; health promotion and disease prevention; and violence against women.

1. Sexual and Reproductive Health

1.1 Maternal health (Table 1.1)

Table 1.1 shows the levels of maternal mortality, expressed as the ratio of deaths per 100, 000 live births. The ratios for India, Myanmar and DR Congo, at 570, 580 and 870 respectively show that childbirth remains a major cause of illness and death among women in this group of countries. Detailed observations from India give a more recent and reduced ratio of 410, but the range among the States within India remains high, from 100 to 700 maternal deaths per 100 000 live births [1,2]. Similarly, Myanmar reports a reduction to 196 in 1996 [1,2].

1.2 Abortion

Table 1.2 summarizes the legal status of abortion in the countries concerned. Unsafe abortion is a major threat to the health of women, constituting up to 14% of maternal deaths, as in the case of India. It has been reported that in India 60% of the abortion deaths in 1994 were of young women between 15 and 24 years of age. In the same year hospital-based data in Myanmar showed that complications of abortion (both induced and spontaneous) were responsible for 50-60% of direct maternal deaths. The most liberal legal framework for managing abortion is in India. But, as shown by the figures in India, legal provisions do not always lead to significant reductions in unsafe abortion due to cultural, medical infrastructural and other reasons.

The World Health Organization has, in 1999, contrived to strengthen measures that reduce maternal deaths, including the prevention of unsafe abortion through an initiative to reduce maternal and neonatal morbidity and mortality "Making Pregnancy Safer". Activities under this initiative will be carried out in member countries, taking into account their legal and cultural norms, starting with 10 priority countries in the 2000-2001 biennium and gradually expanding the number of countries to 50 by the year 2006.

1.3 Contraceptive prevalence and total fertility

Contraceptive use among married women ranges from 8% in the Democratic Republic of the Congo to 53% in Jordan [3]. In India the quoted figure of 41% is relatively low, but is explained by the fact that female sterilization has remained the main method of family planning for a large number of women, with the median age of sterilization at 27 years. Use of male methods such as condoms and vasectomy is negligible. In Myanmar the 17% quoted for 1995 overall is as high as 30% in some areas, representing the commitment of the government to push the family planning programme.

Total fertility rates are 3.1 for India, 4.9 for Jordan, 2.4 for Myanmar and 6.4 for DR Congo. An increase in contraceptive use in the DR Congo will be necessary if the total fertility rate is to be reduced.

2. HIV/AIDS

As shown in Table 2, 4.35% of adults are estimated to have HIV/AIDS in DR Congo in contrast to 1.79%, 0.02% and 0.82% in Myanmar, Jordan and India respectively. However, India (along with Myanmar) have large absolute numbers of cases. For India the total number was 8 491 as of September 1999 and the estimated number of HIV infections is 3.5 million. The male to female ratio of AIDS cases in India is reported to be 3:1. Ninety-one per cent of the AIDS cases are in the age range of 15-49 years and over 4.6% are children. Heterosexual contact is the predominant mode of spread (85%) followed by injections for drug use (7%) and mother-to-child transmission (5%).

In DR Congo, more than half of all adults living with HIV/AIDS by the end of 1997 were female, with HIV-prevalences in sex workers being as high as 34% to 64% (WHO, 1999). Recognizing that injecting drug use does not represent a major route of HIV transmission in the country, it is, however, unclear to what extent sex work is linked to psychoactive substance use [4].

India has HIV prevalence among injecting drug users showing an alarming increase over the last years, it can be safely assumed that a large number of women are affected by, and infected with, HIV through injecting drug use. However, gender desegregated data in this area has not been reported to WHO.

In Jordan, by the end of 1997, one IDU-related and two sexually transmitted AIDS cases were reported.

In Myanmar there were 2854 cases of AIDS as of December 1998 and the estimated number of infections is 440 000. The male to female ratio is 4 to 1, with heterosexual transmission as the predominant mode of spread.

3. Tobacco use among women

Table 3 shows that Myanmar has a high percentage of current regular smokers (16%) while Jordan has 5%. The percentage in India (0.2%) is relatively low; there is no data on DR Congo. Recent initiatives by the world Health Organization are expected to assist countries in reducing tobacco use [5].

4. Violence against women

Violence against women is now and recognized as a major threat to women's health (see Table 4). Studies in India have shown that 19% - 75% of women have experienced physical assault, mainly in a domestic setting. In Myanmar reported physical assault on wives ranged from 3.4% to 9% while mental assault was higher at 11% - 19% [6].

5. Other health concerns

In India, nutrition is a major concern among women and girls. The WHO regional office for South-East Asia has reported that 40% of the population in India consume less than 80% of energy required. The prevalence of severe forms of protein energy malnutrition

(PEM) in preschool children has declined, as has the prevalence of underweight among children below 5 years, but the latter still remains high at 50%. Gender discrimination among girl children in the allocation of food within the family has been reported.

Also in India, tuberculosis was reported to be the leading cause of the death of women with communicable diseases. Women tend to deteriorate when infected. Mental illness affects approximately 15% of all women, compared with 11% among men.

In Myanmar, nutritional concerns are similar to those in India. The prevalence of anaemia is reported among 48% of pregnant women, 36% of non-pregnant women and 30% of under-5 children. Malaria is also a serious problem, with more males than females affected.

Table 1.1: Maternal mortality and attendance at birth

	MM Ratio (1990 estimates)	Skilled attendant at delivery (%) (latest)
India	570	35
Jordan	150	97
Myanmar	580	57
DR Congo	870	Not available

Table 1.2: Legal status of abortion

	Abortion permitted						
	Save life	Physical Health	Mental Health	Rape, incest	Fetal problems	Economic Social	On request
India	X	X	X	X	X	X	X
Jordan	X	X	X				
Myanmar	X						
DR Congo	X						

Table 1.3: Contraceptive prevalence and total fertility rate

	Contraceptive use % of married women		TFR 1995-2000
	All methods	Year	
India	41	1992-1993	3.1
Jordan	53	1997	4.9
Myanmar	17	1992	2.4
DR Congo	8	1991	6.4

Table 2: HIV/AIDS

	HIV/AIDS			Main modes of transmission
	% adults	median % pregnant urban	median % pregnant non-urban	
India	0.82	2.5	2.4	-
Jordan	0.02	0	-	-
Myanmar	1.79	0.8	1	-
DR Congo	4.35	4.3	4	Heterosexual (3666/4744 in 1996)

Table 3: Tobacco use among women

	Current regular smokers Age 15 - 25	
	Percentage	Year or Survey
India	0.20	1996
Jordan	5	1996
Myanmar	16	1996
DR Congo	no data	-

Table 4: Violence against women

	Field data	Sample size	Sample Group	Measure	Location	Time frame	Relationship	All types	Physical violence %	Rape	Notes
India											
3 southern villages	1997P	163	W 15 +	Int. Pers conf	house hold	in current marriage	husband		22.0		Maybe an under estimate as qualitative data indicated some violence was not considered "abuse".
Mumbai (Bombay)	1995-1997	65	Women currently married	Inter personal conflicts	community	in current marriage	husband		49.2		
Rural areas in 2 states	1993-1994	1, 842	Women currently married. Inter personal conflicts	Inter personal conflicts	house hold	in current marriage	husband		40.0		Women were interviewed five times. Additional methodology information obtained from personal communication with researchers

CEDAW/C/2000/I/CRP.3/Add.3

	Field data	Sample size	Sample Group	Measure	Location	Time frame	Relationship	All types	Physical violence %	Rape	Notes
Tamil Nadu	1993-1994	983	Women currently married	Inter personal conflicts	house hold	in current marriage	husband		37.0		Women were interviewed five times. Additional methodology information obtained from personal communication with researchers
Uttar Pradesh	1993-1994	859	Women currently married	Inter personal conflicts	house hold	in current marriage	husband		44.7		Women were interviewed five times. Additional methodology information obtained from personal communication with researchers
Uttar Pradesh	1996	6,926	married men	Inter personal conflicts	community	in current marriage	husband			28.0	Husbands reported on their violence against their wives
Uttar Pradesh	1996	98	Women currently married	Inter personal conflicts	two villages	in any relation ship	husband			68.0	

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2. WHO/UNICEF Revised 1990 estimates of maternal mortality, Geneva (1996).

3. United Nations Population Division, New York (1999)

4. WHO/UNAIDS Epidemiological fact sheets on HIV/AIDS and sexually transmitted diseases, Geneva (1999).

5. WHO, Tobacco Free Initiative, (1999).

6. WHO, Data-base on violence against women (1999)